Refugee Health Assessment Form

Please return completed form within 45 days to :
Virginia Department of Health Division of TB Control Newcomer Health Program
P.O. Box 2448, Richmond, VA 23218

Name (Last, First, MI): _____ , _____ __ __ **US Arrival Date:**

Alien Reg #: A **File #:** **Gender:** **DOB:** **TB Status:**

Country of Origin: **Volag:**

Country of Exit: **Dist Mailed To:** **Date Mailed:**

THE HEALTH DISTRICT PROVIDING THE HEALTH ASSESSMENT COMPLETES THIS PORTION OF FORM

Was The Refugee Located ? (circle one) Yes / No If **Not** Located, Provide Reason If Known. _____
If The Refugee Was Not located, You Can Not Provide An Assessment. Do Not Continue But Return This Form to VDH Refugee Health Program.
If The Refugee Was Located, Provide Name of The **Health District** Providing This Health Assessment. _____
Person Completing This Form : _____ Phone # : (_____) _____ Date of Assessment: _____/_____/_____

Your district must decide whether or not to bill Medicaid for this initial health assessment.
Forms received without checking YES *or* NO will be returned delaying compensation.

YES ☐ Check here if your District **INTENDS** to bill the refugee's Medicaid for elements included in this Health Assessment. By checking here, the health district indicates it will accept the Medicaid reimbursement allowance for elements within this health assessment. Your district will **not** be reimbursed by DSS administered Refugee Medical Assistance Funds.

NO ☐ Check here if your District **DOES NOT INTEND** to bill Medicaid for elements in this Health Assessment. By checking here, the health district indicates that for this health assessment it will accept the reimbursement from DSS administered Refugee Medical Assistance Funds, facilitated by DTC. Further, the District agrees **not** to bill the refugee's Medicaid for *any* element included in this initial health assessment. Subsequent health visits can and should be billed to the refugee's Medicaid or other medical insurance.

LEVEL I: REQUIRED MINIMUM: Assessment for Tuberculosis Disease / Infection (May be completed by PHN, NP, PA, or MD)
(Level I only = $75.) *Each element requires an appropriate answer:*

Mantoux Skin Test Reaction
- ☐ Negative
- ☐ Positive
- ☐ Given, not read
- ☐ Not done, explain: _____

Chest X-ray (in US) if PPD + &/or S/S
- ☐ Normal (not TB)
- ☐ Abnormal (TB suspected)
- ☐ N/A (negative PPD & no S/S of TB)

Therapy (if indicated)
- ☐ TX for suspected or confirmed TB disease is considered
- ☐ Therapy for LTBI indicated
- ☐ Based on evaluation, no therapy indicated now

	(**Circle One**)
1. What is the Refugee's P*rimary* Language (other than English)? _____	
2. Was an interpreter *necessary* to conduct this refugee's health history and assessment? (If **Yes**, complete 3, 4, & 5 ---- If **No**, skip to Level II)	Yes / No
3. Was a competent, trained interpreter *available* to facilitate this refugee's health history and assessment?	Yes / No
4. Was the trained interpreter *used* to facilitate this refugee's health history and assessment?	Yes / No
5. Was a *family member* or friend used to provide the interpretation?	Yes / No

LEVEL II: Health History and Assessment (May be completed by PHN, NP, PA, or MD*)*
(Level I and II = $210. if age 11 years or less; $250. if age 12 years or more)
For compensation for this level, Level I is required and ***each*** item in Level II requires the most appropriate response**.**

Review of the refugee's health history and…	**(Circle One)**
2) The gross inspection / assessment / systems review. Question for current health problems?……..WNL? ……	Yes / No
3) A gross evaluation of vision and hearing (eye chart and whisper test) ……WNL? ……	Yes / No
4) A gross dental inspection / assessment (gross inspection of the oral cavity) ……WNL? ……	Yes / No
5) STD follow-up for any STD *if identified* on federal form DS 2053 or OF-157 … ……	Done / NA
6) Is this refugee's weight appropriate for his / her height? ……	Yes / No
7) Is this refugee's hemoglobin **& / or** hematocrit appropriate for his / her age & sex? ……	Yes / No
8) If 5 years old or over, is this refugee's Blood Pressure grossly within normal limits? (If age < 5, circle Yes)……	Yes / No

9) Review the refugee's immunization history. Determine if his/her immunization status is current and to date for age. *Indicate if any update is necessary by checking yes / no to each item*. **You are encouraged to begin the update (give immunizations) during this visit and then refer appropriately for follow up through your district immunization clinic.**

Diphtheria, Tetanus, and if indicated for age, Pertussis ……	Yes / No
Polio ……	Yes / No
Measles, Mumps, and/or Rubella ……	Yes / No
Hepatitis B (series requires referral to immunization clinic) ……	Yes / No
Haemophilus influenzae type B ……	Yes / No
Varicella ……	Yes / No
Pneumococcal (necessary if indicated by age or health condition) ……	Yes / No
Influenza? (necessary if season, age, and /or health condition) ……	Yes / No

10) Hepatitis B Screening: (Africa, Asia, Middle East; at times, former Soviet States & Eastern Europe) ……	Done / NA
11) Parasite screening: (Africa, Asia, Middle East, and if from a refugee camp) ……	Done / NA
12) **IF FEMALE**, is this refugee currently pregnant?……	Male / Yes / No
13) General mental status assessment (orientation to person, place, time, as age appropriate)? WNL? ……	Yes / No

Level III: Expanded Health Assessment (A PHN, NP, PA, or MD may complete this portion)
(Level I, II, and III = $230. if age 11 or less; $270. if age 12 or more)
For compensation for this Level, Level I and II are required and sections specific to the refugee's age require the most appropriate response.

(Circle one)

1) An assessment, *that at a minimum, includes listening to heart & lung sounds.* A diagnosis is not necessary, but if sounds are abnormal a referral is necessary in Level IV.

Done / Not Done

2) Age specific recommended screening:

a) **age <5 years**:
- 1- Measure head circumference …….. WNL? Yes / No
- 2- Assessment for developmental milestones …….. WNL? Yes / No

b) **age 5-15 years**:
- 1- Provide nutritional assessment (if ht & wt <5th%) …….. Done / NA
- 2- Developmental level / mental status assessment ……. WNL? Yes / No

c) **age >15 years:**
- 1- Further evaluation if weight more than 10% under normal range OR if more than 40% over normal range. …… Done / NA
- 2- Evaluation for hypertension if BP elevated. …….. Done / NA
- 3- CBC, platelets, if hematocrit less than 30%. …… Done / NA
- 4- VDRL if indicated by history or abnormal exam. …… Done / NA
- 5- Offer HIV testing if indicated by history or abnormal exam. … Done / NA

d) **age >46 years or if indicated at any age**:
- 1- Stool exam for blood (hemoccult). …… Done / NA
- 2- Fasting glucose. …… Done / NA
- 3- Fasting cholesterol. …… Done / NA
- 4- Cancer information and / or evaluation as appropriate. …….. Done / NA

LEVEL IV: PUBLIC HEALTH NURSE CASE MANAGEMENT

Includes any referrals as necessary based on health assessment. This Level is reimbursed once @ $100. regardless of the number of referrals. Make sure the referral corresponds to findings as documented in the previous Levels. If not, the referral will not be counted.

(Circle one)

1) Referral for consideration of therapy for TB infection or disease? …… yes / no
2) Referral for abnormal vision finding? …… yes / no
3) Referral for abnormal hearing finding? …… yes / no
4) Referral following a **normal** dental inspection? …… yes / no
5) Referral for follow up due to an **abnormal** dental inspection? …… yes / no
6) Referral necessary for an STD/HIV finding? …… yes / no
7) Referral necessary for abnormal weight finding? …… yes / no
8) Referral necessary for anemia / malaria findings? …… yes / no
9) Referral necessary to update immunizations per ACIP guidelines? …… yes / no
10) Referral necessary for Hepatitis B? …… yes / no
11) Household contact testing for Hepatitis B necessary? …… yes / no
12) Referral required for abnormal parasite screening? …… yes / no
13) Referral necessary for developmental delays? …… yes / no
14) Referral necessary for mental health evaluation? …… yes / no
15) Referral for any other problems identified at health assessment? …… yes / no

This form serves as both an invoice tool and health data collection tool, please complete appropriately and accurately. The program can reimburse Health Districts only. The program cannot reimburse private physicians or non health department clinics. However, a health district may choose to contract with a health provider to provide the health assessment. The district then accepts responsibility for reimbursing their contractor.

PLEASE RETURN FORM TO VDH/RHP AS SOON AS POSSIBLE AFTER HEALTH ASSESSMENT IS COMPLETED
Reimbursement Can Only Be Made With Proper Documentation
Forms received more than one year after the assessment date will be returned and the district will not be paid for the services.

Questions?
Call the Newcomer Health Program (804) 864-7910/11
e-mail anna.davis@vdh.virginia.gov or julie.coggsdale@vdh.virginia.gov
fax number (804) 864-7913

VDH/NHP reviewed 08/04